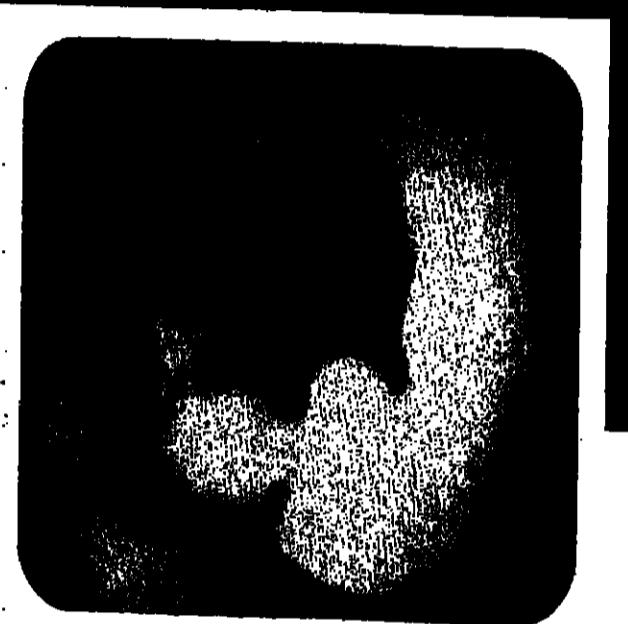


The Pseudo-ulcer



Ulcer-like symptoms: no G.I. pathology

The patient is convinced it's an ulcer. However, symptoms are not quite typical, and x-ray findings are negative. These findings and the results of additional diagnostic procedures exclude an organic basis for the patient's complaints. A diagnosis of "upper functional gastrointestinal disorder" is made, which is supported by the fact that episodes of painful symptoms coincide with episodes of excessive anxiety, as indicated by the history.

It may be useful to explain to the patient the mechanism by which emotions upset normal G.I. functioning, resulting in hypersecretion and hypermotility and thus causing such symptoms as nausea and epigastric pain. In upper functional gastrointestinal disorders, counseling from the primary physician can often help the patient to understand how excessive anxiety may cause flare-ups of G.I. symptoms.

A disproportionate number of patients seen by the general practitioner suffer from functional disorders, as do more than half of those seen by the gastroenterologist.* Where milder cases may respond to counsel-

An adjunct in anxiety-related upper functional G.I. disorders

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Symptomatic relief of hypersecretion, hypermotility and anxiety and tension states associated with organic or functional gastrointestinal disorders, as an adjunctive therapy in the management of peptic ulcer, gastritis, duodenitis, irritable bowel syndrome, spastic colitis, and mild ulcerative colitis.

Contraindications: Patients with glaucoma; prostate hyperplasia and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-active drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librax (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in

ing alone, if symptoms are severe and disabling to any degree, a suitable regimen may include medication to reduce the symptoms and the excessive anxiety that often provokes these distressing symptoms. In these cases, Librax as an adjunct can greatly contribute to the course of therapy. Its dual action can offer relief of both painful symptoms and excessive anxiety, because each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br. The anti-anxiety action of Librax® (chlordiazepoxide HCl) makes Librax exceptional among drugs for certain gastrointestinal disorders associated with excessive anxiety; the clidinium bromide (Quarzan™) component furnishes dependable antisecretory-antispasmodic action. Dosage is flexible; it may be adjusted according to your patient's requirements within the range of 1 or 2 capsules three or four times daily, up to 8 capsules daily in divided doses.

*Rome HF, Bramble TL: Orientation and mechanism of functional disorders: clinicophysiological correlation, chap. 188, in *Gastroenterology*, edited by Bockus HL. Philadelphia, WB Saunders Company, 1965, p. 1110.

pregnancy, lactation, or in women of childbearing age, requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentially drug such as MAO inhibitors and phenothiazines. Observe unusual reactions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, dizziness, and drowsiness have been reported. Use of any drug in

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No. 23

making
rounds

world news of medicine and its problems

and Medical News

Arteriosclerotic Basis Denied For Bulk of Senile Dementia

Prospects Grim For Some States In Liability Mess

By EDWARD GROSSMAN
Medical Tribune Staff

NEW YORK—Will it be a long hot summer on the malpractice front?

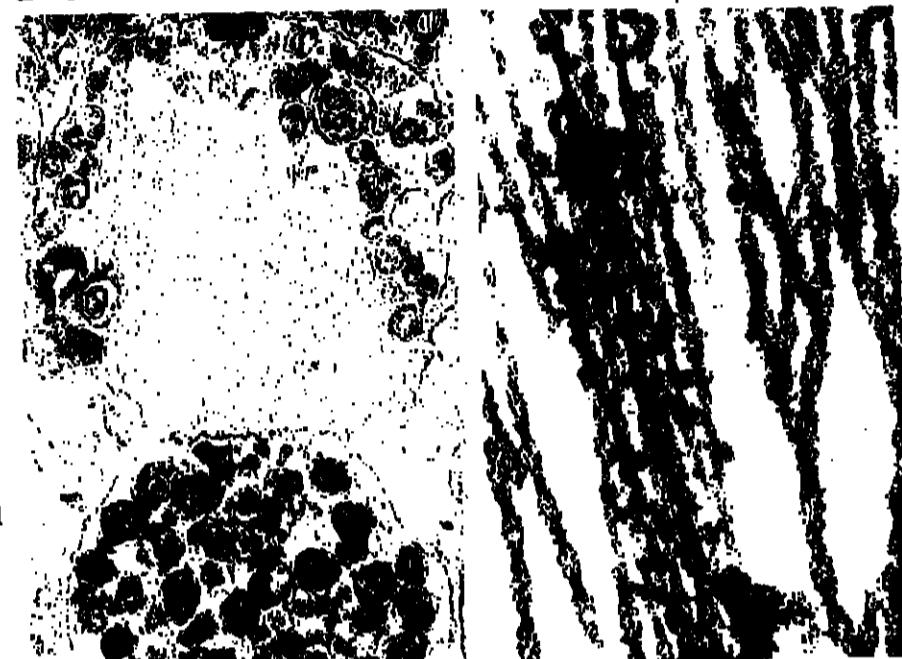
Based on nationwide interviews conducted by MEDICAL TRIBUNE with physicians, medical society executives, political leaders, and lawyers, the forecast is for things to stay relatively cool in some states, thanks as much to good luck and good will as good legislation. But in others, it will probably not be possible to avert the collapse of professional liability-coverage systems and widespread interruption of medical services.

Some Points of Consensus

While most of those interviewed called the situation "fluid" "unclear," or "confused"—with local predictions ranging from bleak to guardedly optimistic—some points of consensus emerged.

It was agreed that few states, however fortunate for the time being, would escape having to grapple with the basics of malpractice reform, as stop-gap legislative measures expire and an aroused public and medical profession demand more rational protection and indemnification. No single reform is the answer, it was emphasized, and the package of changes that

Continued on page 4



"Twisted tubules" characteristic of the neurofibrillary tangle in senile brain, right, may be a pair of helically wound filaments or a periodically constricted tubule. Contents of abnormal neurites making up neuritic plaque, left, are seen as dense bodies, degenerating mitochondria, "twisted tubules."

It Can't Be Extrapolated

Belgian Expert Says UGDP Study Is Valid Within Own Context

By JAMES MAGEE
Medical Tribune World Service

GENEVA—"The U.G.D.P. study is quite valid within its own context, but it simply cannot be extrapolated to the whole diabetic population," according to Dr. Jean Pirart, secretary of the Belgian Diabetic Association.

Dr. Pirart was among several leading European investigators and clinicians asked by MEDICAL TRIBUNE to comment upon the clinical implications of recent Biometric Society analysis of the University Group Diabetes Program study. The 1970 U.G.D.P. report claimed a higher than expected cardiovascular mortality associated with oral hypoglycemic agents, but no difference in overall mortality.

Third of a Series

"In the view of Belgian diabetologists, the hypoglycemics have to be used according to the correct indications, and the correct dosages. If these conditions are met, then we do not consider that there is a high risk of toxicity."

Dr. Pirart said that at present in Belgium, the general pattern of diabetes therapy is: insulin—20 per cent; diet—about 40 per cent of patients; oral drugs, combined with dietary control—about 40 per cent.

Dr. Pirart warned, though, that he

The neuropathologist, who heads the Department of Pathology at Albert Einstein College of Medicine, said that observations on autopsied brains have proved that "relatively few cases of senile dementia are accounted for by atherosomatic changes in major arteries."

Instead, Dr. Terry considers the most common type of senile dementia

Continued on page 13

Dr. Warren Honored at Bunker Hill Ceremonies



Dr. Joseph Warren dying of his wounds, in John Trumbull's engraving, "Battle of Bunker's Hill."

Medical Tribune Report

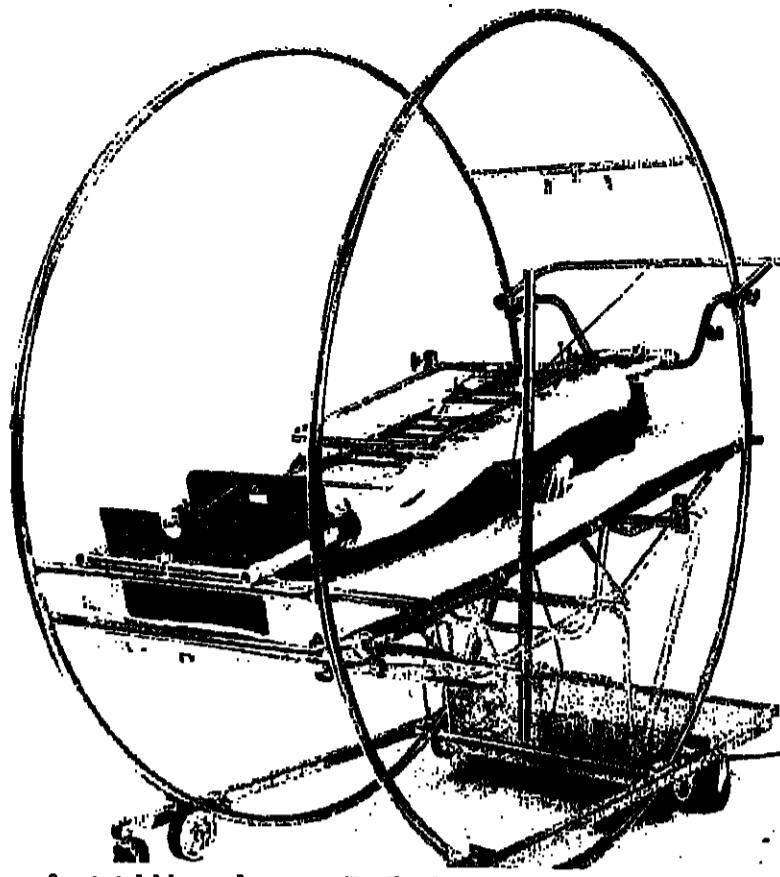
BOSTON—When this city's daylong ceremony and reenactment of the Battle of Bunker Hill took place earlier this week, one of those honored was Dr. Joseph Warren, who was killed at

Bunker Hill. Dr. Warren's revolutionary role was more important than that of better known Paul Revere, whom he sent on at least one of his famous rides.

Colorful, idealistic and democratic,

Continued on page 12

Lung Emboli Held Down in Hip Replacement



After surgery for total hip replacement Dr. Louis Brady recommends patients be placed on the Stryker circle bed, shown here. To advance the healing process, his patients were turned to a new position by nurses every eight hours and left at that position as long as they could tolerate it.

Medical Tribune Report

SAN FRANCISCO—Only five of 360 patients who underwent 560 total hip replacements showed evidence of pulmonary embolus—and none of the five died—in a prospective study of prophylactic measures described here to the American Academy of Orthopaedic Surgeons.

The use of any of five drugs (dextran, heparin, warfarin, aspirin, and phenylbutazone), where indicated, was combined with standard nursing care measures, including antiembolism hose, calf exercise, and early mobilization, it was reported by Dr. Louis P. Brady, chief of orthopaedics at Florida Hospital, a private hospital not affiliated with any medical school, in Orlando, Fla.

Such a multifaceted approach can reduce significantly the incidence of thromboembolic phenomena, he said.

Ninety-five per cent of the 360 patients received dextran 40, and 19 per cent received a combination of dextran and sodium warfarin. Heparin was used only to treat pulmonary embolus.

Meticulous Care Essential

Four patients developed thromboembolism ("as opposed to phlebothrombosis"); 53 developed edema and were "clinically felt" to have phlebothrombosis. All patients with phlebitis developed edema.

"No single parameter will accomplish these results," Dr. Brady cautioned. "Meticulous care and careful observation of the patient by a discerning and interested surgeon is mandatory to [the protocol's] success."

"Delegation of the ultimate responsibility to others is usually not possible. One must develop a protocol which will suit his own situation and then rigidly adhere to it if successful results are to be anticipated."

"Some people think [anti-embolic] hose are a big thing," Dr. Brady told

supine, they were kept in 20° of Trendelenburg.

Dr. Brady stressed the importance of the role played by the nurses in seeing that the patients followed instructions for active and isometric exercises and the recognition of early edema.

Antiembolism hose were used only when there was evidence of clinical edema, in which case they were applied to both legs below the knee only.

"I feel their routine use increases the likelihood of heel sores," Dr. Brady said, "and prohibits good skin care."

None of the patients in this study developed heel sores.

If edema worsened on the day after it was discovered, sodium warfarin was given (15 mg, the first day and 10 mg, the second), to maintain the prothrombin time at one and a half to two times control, with daily prothrombin times being checked the third day.

When pulmonary embolus occurred, as it did in five patients, sodium warfarin was discontinued and heparin started. These five were the only patients whose activity was restricted, and then it was only for three to four days, until symptoms subsided.

Patients with thrombophlebitis were given phenylbutazone (100 mg, t.i.d.), usually for three days or until symptoms subsided.

Stand to Tolerance on 3d Day

All patients were allowed to stand to tolerance in the Stryker circle bed beginning on the third day after surgery.

On the sixth day, the patients were transferred from the Stryker bed to a regular hospital bed, retention sutures were removed, and ambulation in parallel bars was begun.

Protected weight bearing was allowed on the sixth day for patients with reconstructive procedures; unprotected weight bearing was allowed for patients with uncomplicated osteoarthritis or rheumatoid arthritis.

Sutures were removed on the 13th day and the patients were discharged on the 14th day on crutches or with walkers, with no medication other than supplemental vitamins and iron.

Men with at least 50 per cent obstruction in two or more vessels scored significantly higher on anxiety and depression, but were not remarkably higher on hypochondriasis. There was no trend in hysteria scores. The more seriously affected men manifested significantly less symptom denial.

No Angina Association

Angina intensity rating had no significant association with activity survey scores.

"Men with more severe and frequent angina scored much higher on hypochondriasis and on hysteria," Dr. Zyzanski reported, "entirely due to a greater tendency to admit symptoms. These men were also higher on the depression scale."

He said the lack of association between Type A scales and angina intensity "is consistent with the hypothesis that Type A characteristics precede rather than follow from the atherosclerotic process."

Associated with Dr. Zyzanski in the study were Drs. C. David Jenkins, Thomas J. Ryan, Steven H. Lefkowitz and Margaret Everist.



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Study Supports Link Of Type A Behavior With Heart Disease

Medical Tribune Report

NEW ORLEANS—Can a physician cite scientific evidence to back up a warning to a business executive patient that his hard-driving, competitive, intensely-committed behavior may cause coronary heart disease?

The association has been demonstrated, but skepticism has persisted because of a lack of knowledge as to how psychological factors might relate to the pathological processes involved in coronary disease.

Now Boston University investigators have provided data for the practitioner to use. Dr. Stephen J. Zyzanski presented the findings at the annual meeting of the American Psychosomatic Society.

Artery Blockage Rated

The double-blind study at the Boston University Medical Center covered 95 men, most of them in the 45-to-55-year age range, who underwent coronary angiography. Cardiologists reviewed cineangiograms and rated the per cent by which each of the four major arteries of the heart—main left, LAD, circumflex, and right coronary—was blocked by atherosclerotic lesions at their most obstructed points.

Before angiography the patients completed self-administered tests to cover behavior, anxiety, neuroticism, hypochondriasis, and hysteria. The coronary-prone behavior pattern—Type A—was characterized as hard-driving, competitive, impatient, hurried, and intensely committed to vocational goals. Angina intensity was recorded from histories.

It was found that 55 men with 50 per cent or greater arterial obstruction in two or more vessels scored statistically higher on the scales of the activity survey than did 37 patients with lesser obstruction.

Men with at least 50 per cent obstruction in two or more vessels scored significantly higher on anxiety and depression, but were not remarkably higher on hypochondriasis. There was no trend in hysteria scores. The more seriously affected men manifested significantly less symptom denial.

Effect on Fetal Development

"While these ridges have no relation to malignancy," he said, "they are evidence that diethylstilbestrol has affected the development of the female genital tract in the fetus. In addition, nonmalignant abnormalities of the lining of the vagina were noted in approximately one-half the exposed, compared to only 1 per cent of the controls."

"Almost all of the exposed subjects had similar tissue changes in the lining of the cervix, in comparison to only one-half of the controls. Biopsies of the abnormal areas of the vagina and cervix showed the presence of benign glandular epithelium (vaginal adenosis and cervical erosion) and associated inflammatory changes."

At the same time, he said that survival rates for young women in whom the malignant changes were detected early and who underwent hysterectomy or other surgical procedures, have been high.

4 Investigators Near Trial In 'Illegal Dissection' Case

By HARRIET PAGE
Medical Tribune Staff

BOSTON—More than a year after their indictment for "illegal dissection" under an 1814 grave-robbing statute, four Boston City Hospital physicians will at last come to trial.

The four, Drs. Leon D. Sabath,

Leonard Berman, David Charles, and Agnetta Phillipson, had participated in a study of women about to undergo abortions designed to see if erythromycin and clindamycin reach the fetus in therapeutic concentrations after oral administration to the mother.

Their finding, based on examination of amniotic fluid and fetal tissue and reported in *The New England Journal of Medicine* in June, 1973 (288:1219), was that both agents crossed the placenta and that fetal tissue levels reflect maternal dose levels. The authors concluded that, providing the infecting organism is sensitive, "both antibiotics may be reasonable alternatives to penicillin in the treatment of intrauterine infections."

On May 27, Neil Chayet, defense attorney for the four, appeared in Suffolk County Superior Court before Judge John J. McNaught to argue motions for discovery of the Commonwealth case and to get the bill of particulars from the prosecutor, Assistant District Attorney Newman A. Flanagan. And on June 24, Mr. Chayet will argue substantive motions for dismissal.

"I was exactly wrong in my prediction for the Edelin case—that he would be acquitted," said Prof. Curran. "But this time I feel confident, and that this case will get a better showing."

"The great outcry over the verdict in

the Edelin case should put this one in

better perspective. The prosecutors in the Edelin case were attacked vociferously on both medical and legal grounds. The judge's determination to give no sentence may reflect a responsiveness to this.

Panning Rate Squeeze



Playing his flute to attract a crowd, Dr. Louis Lewis invited listeners in San Francisco to take a pamphlet on the malpractice insurance question.

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748 or 19.2 per cent.

Italians Flock to Medicine

Medical Tribune World Service

ROME—More Italian students are studying medicine than any other subject in the national university system, according to figures released by the National Institute of Statistics for the 1974-1975 academic year.

With a total of 716,375 full-time students, those enrolled in the faculty of medicine and surgery number 197,748 or 19.2 per cent.

Outlook Grim in Some States In Liability Insurance Mess

Continued from page 1

may serve one state might fail in another, where circumstances are different.

Nevertheless, certain ideas for reform were mentioned repeatedly as necessary or promising, and politically feasible:

- A ceiling on liability and awards.
- Pre-trial screening of suits by a panel whose findings and recommendations would be introduced as evidence to the jury.

- Reduction of the statute of limitations to cut the "long tail" of liability.

- Establishment of non-profit mutual insurance companies capitalized and operated by state medical societies, writing malpractice policies exclusively.

Also cited as desirable, though less likely to be achieved in view of political factors, was the imposition of a sliding scale of contingency fees on payments to plaintiffs' lawyers, and removal of malpractice claims entirely from the tort and jury system to one of binding arbitration, as in workmen's compensation.

Actions by States

In several states which are expected to weather the coming months—notably Indiana (MT, April 23), Florida, and Idaho—some or all of the first group of reforms have already been enacted. But in two key states where a prolonged breakdown of services has occurred or is anticipated—California and New York—the only major bills that have become law are those setting up compulsory joint underwriting associations, regarded as short-term, emergency devices to provide coverage as individual commercial carriers quit the malpractice field or hike premiums up to 600 per cent.

The Indiana legislation, signed by Gov. Otis Bowen, M.D. and taking effect July 1, was praised by respondents in other states, who said they were studying it as a model. Its principal features include a \$100,000 ceiling on damages against any one physician, with an additional \$400,000 available from a "catastrophe" fund capitalized by all the health-care providers in the state; a reduction of the statute of limitations from three years from date of discovery to two years from date of the negligent act; and pre-trial review of all suits by screening panels of three physicians and a lawyer.

Questioned on her personal plans, Dr. Lee said "the climate of practice has become ridiculous—I'm close to being in a quandary. I fully understand and applaud the anesthesiologists' attention in California."

It was the walkout of San Francisco-area anesthesiologists from May 1 to May 28, in protest against premium increases of 375 per cent, that catalyzed California's malpractice crisis, perhaps the worst in the nation so far. A special session of the legislature, called by Gov. Edmund G. Brown, Jr., failed to resolve any outstanding issues, even though strike-bound hospitals offered to pay their housestaff's insurance costs for an interim period. Militant anesthesiologists, with some support from the state medical Association, have things work out."

A similarly cautious note was struck by Florida's Gov. Reubin Askew when he signed that state's reform package: "We have had, until just recently, no real experience in state government in

confronting the malpractice issue."

The Florida legislation follows Indiana's in limiting liability, reducing the statute of limitations, and mandating pre-trial screening. It also sets up a Joint Underwriting Association of all liability companies in the state, in spite of the fact that a U.S. district judge, ruling on a suit brought by the state medical society, has enjoined the major carrier, Argonaut, from leaving Florida or increasing premiums until the end of the year.

'A Good Start'

Don Jones, Executive Director of the Society, told MEDICAL TRIBUNE that the package is "a good start, but there's more to be done in the way of legal reform before premiums can be controlled." He said that the chances of job actions and strikes by physicians had been considerably diminished.

The prospect in Maryland is cloudier, in part because Gov. Marvin Mandel and many legislators are opposed to changing malpractice law.

The only steps taken so far have been by the insurance commissioner, Thomas J. Hatem, allowing St. Paul Fire and Marine a hefty increase in premiums through July, and by the state medical society, authorized by the legislature to form a mutual company to pick up policies of physicians who dropped the commercial carrier June 1.

John Sargeant, executive director of the Medical Society, declared in an interview with MEDICAL TRIBUNE that he was confident the new company would be able to give coverage while lobbying for reform continues, thus avoiding walkouts by physicians.

His optimism is not shared, however, by all physicians in the state, some of whom are worried about the economic viability of their own company. Dr. Lois Lee, chief of anesthesiology at Holy Cross Hospital, Silver Spring, said that "many of our questions about the company have not been answered satisfactorily, and therefore I wouldn't be surprised if at least some anesthesiologists take a 'leave of absence' this summer until the company proves that it can deliver. There'll be emergency service, of course, but we'll be stretched thin."

Climate of Practice 'Ridiculous'

Questioned on her personal plans, Dr. Lee said "the climate of practice has become ridiculous—I'm close to being in a quandary. I fully understand and applaud the anesthesiologists' attention in California."

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"I don't foresee any federal legislation or involvement this year," Mr. Norrell added. "The Kennedy and Inouye bills are dead letters."

were demanding to see signs of action on reform of malpractice law before they would perform any but emergency procedures.

Dr. Carl Goetsch, an obstetrician and gynecologist, president of the California Medical Association, told MEDICAL TRIBUNE that he doubted there would be a definitive end to the strike until the legislature began to move on Gov. Brown's proposals for "thorough reconsideration of the legal and medical professions, and the insurance industry."

Among the first reforms, Dr. Goetsch said, would have to be "a hard and fast statute of limitations, and a collateral source rule so that plaintiffs could not recover malpractice damages when they were already covered for the same injury by some other policy." He said he would like to have a ceiling on awards, but "given the facts of life in California, there's not much chance of that."

His comments were endorsed by Dr. David S. Rubsamen, a Berkeley physician and lawyer who is an expert in malpractice law. Dr. Rubsamen added that in California, "the immediate problem is not caused by the threat of the unavailability of coverage, as in New York, but by exorbitant premiums, which are usually a function of big losses in judgments paid out and insurance company investments in the stock market that take a beating."

The Joint Underwriters Association, or a doctor's company, are no answers to that at all. Rates would continue to be sky-high. To bring them down, there must be changes in the law. On that score, as far as California is concerned, my crystal ball does not look good."

NY Crisis May Be Worst

Potentially the worst crisis may be brewing in New York. On the eve of a critical meeting of the House of Delegates of that state's medical society, which voted 143-82 to reject a so-called "compromise" reform bill put together by the legislature and signed by Gov. Hugh Carey, several physicians expressed the opinion to MEDICAL TRIBUNE that however the vote went, there was a chance of strikes soon. The bill creates a compulsory joint underwriting pool of 200 companies, backed up by the state insurance fund, to write policies when Argonaut pulls out July 1, and provides for the establishment of a doctor-run company. But it makes none of the changes in the adjudication of suits asked for by the medical society.

Both the A.M.A. and H.E.W. are strongly disposed to continue letting state legislatures and organizations try to solve the malpractice problem for themselves. Bruce Norrell, an A.M.A. staff attorney, told MEDICAL TRIBUNE that in line with this principle, the Association will debate a proposal at its annual convention for a reinsurance company sponsored by the A.M.A. The company would provide excess-loss coverage for those state medical societies which set up their own mutual companies, on the condition that there have been fundamental reforms made in the tort law of the state.

"I don't foresee any federal legislation or involvement this year," Mr. Norrell added. "The Kennedy and Inouye bills are dead letters."

practice, also hoped that the House of Delegates would approve the bill, even though he too was "disappointed" with the legislature.

"The people in Albany did nothing to affect costs," he said, "which is a profound failure of responsibility to their constituents, our patients. However, I would certainly hope that doctors would not feel it necessary to walk off. The consequences would be incalculable—some hospitals would be in bankruptcy within weeks."

Dr. Norman S. Blackman, cardiologist and president of the Kings County Medical Society, took much dimmer view of the bill and flatly predicted cessation of non-emergency services beginning July 1, no matter what the House of Delegates decided.

"The bill is dismaying," Dr. Blackman said. "It's strictly a lawyer's bill that for the first time says in black and white that the best way to get medical care is to threaten to sue your doctor. The concept of a doctor-run company doesn't impress me—it's just another way of paying ransom to the legal system. After June 1, I won't accept new patients, and after July 1, I will stop practicing if there isn't an acceptable reform package in the works, similar to Indiana's."

Intermediate Prospects

Elsewhere around the country, dozens of states that are involved in the process of malpractice salvage and reform seem to be facing immediate prospects neither so comparatively encouraging as Indiana's and Florida's, nor as dire as California's and New York's. Major reform bills including joint underwriting schemes are approaching the desks of the governors of Tennessee, Washington, Texas, North Carolina, and Iowa.

In Michigan, the state supreme court has handed down a decision allowing regulation of lawyers' contingency fees; Michigan is only the second state, after New Jersey, where such a ruling has been made. And in a handful of unusual states such as Hawaii and New Mexico, no serious malpractice problem exists, due in large part to the success of screening panels set up years ago, which have excellent relations with the courts, lawyers, and the insurance industry. H. Thom Thorson, Hawaii Medical Association executive director, says that there has not been a court reversal of the Hawaii panel's recommendation since 1959.

A.M.A. Reinsurance Plan

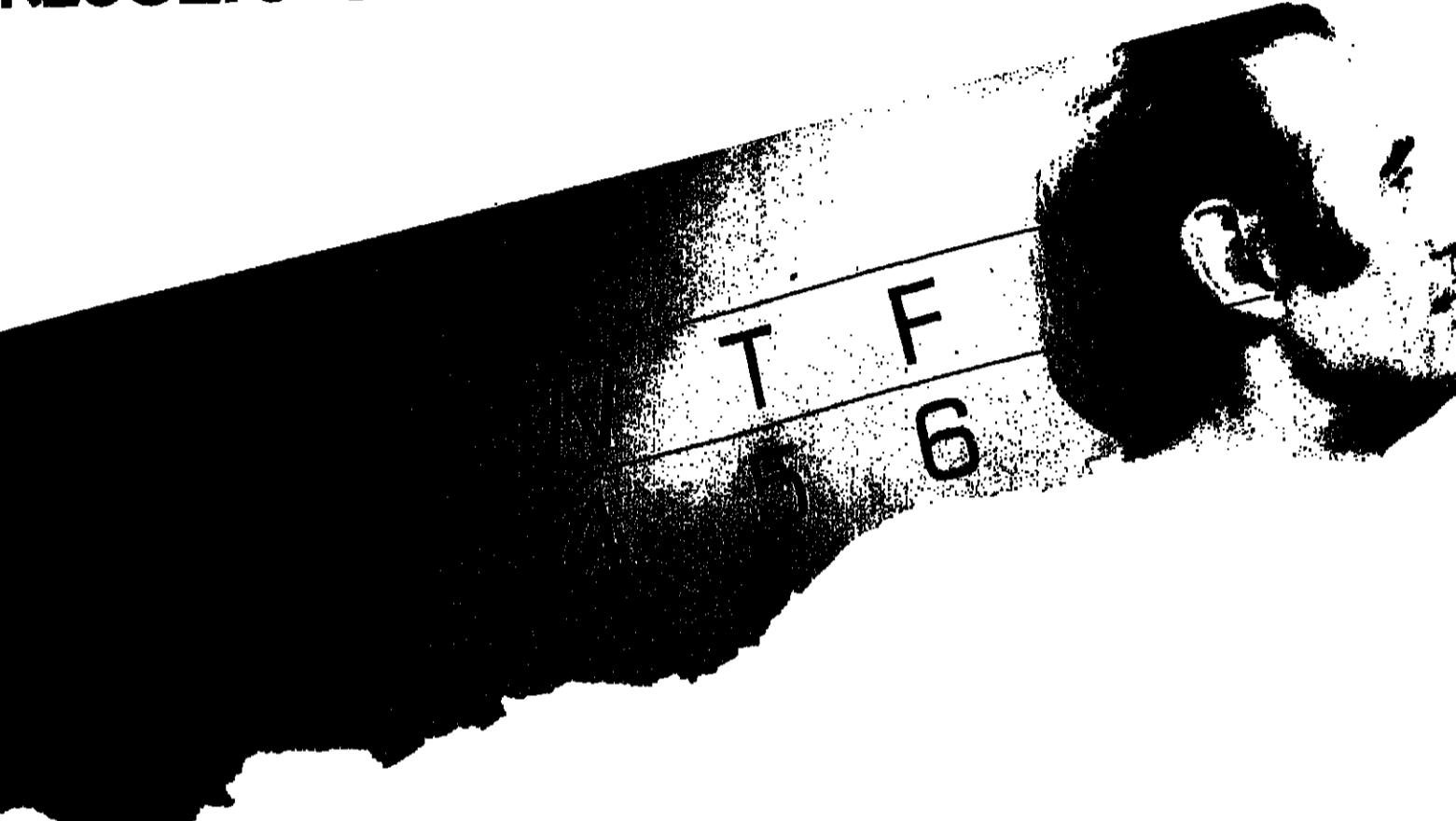
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*Data on file at Sandoz Pharmaceuticals.

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Contraindications: Severe central nervous system depression, comatoses states from any cause, hypertension or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides; carefully consider benefit versus risk in less severe disorders. During pregnancy, administer only when the potential benefits exceed the possible risks to mother and fetus.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and thrombocytopenia, in aplastic patients, anticoagulant medication should also be monitored. Phenothiazine neuroleptic observed primarily in patients receiving larger than recommended doses, is characterized by diminution of visual acuity, brownish coloring of vision, and impairment of night vision; the possibility of its occurrence may be reduced by remaining within recommended dosage limits. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving), and increase dosage gradually. Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating orthostatic hypotension since phenothiazines may induce a reversed epinephrine effect on occasion. Daily doses in excess of 300 mg should be used only in severe neuroleptic conditions.

Adverse Reactions: **Central Nervous System:** Drowsiness, especially with large doses, early in treatment; intrusiveness, pseudoparkinsonism and other extrapyramidal symptoms; rarely, nocturnal

confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. **Autonomic Nervous System:** Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. **Endocrine System:** Gastroenteritis, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. **Skin:** Dermatitis and skin eruptions of the urticaria type, photosensitivity. **Cardiovascular System:** ECG changes (see *Cardiovascular Effects* below). **Other:** Rare cases described as paroxysmal swelling.

The following reactions have occurred with phenothiazines and should be considered: **Autonomic Reactions:** Nodules, obstruction, anorexia, paralytic ileus. **Cutaneous Reactions:** Erythema, urticaria, angioneurotic edema, exanthema, hives, pseudogout, thrombocytopenia, anemia, aplastic anemia, pancytopenia. **Allergic Reactions:** Fever, myalgia, asthenia, angioneurotic edema, asthma, Raynaud's phenomenon, tachycardia. **Endocrine Disturbances:** Retention, incitiveness. **Obstetrics:** Hypertension, behavioral effects suggestive of a paradoxical reaction, including excitement, bizarre dreams, aggravation of psychoses, and toxic confusional states; following long-term treatment, a peculiar skin-eye syndrome marked by progressive pigmentation of skin or conjunctiva and/or accompanied by discoloration of eyes, sclera and cornea; stellate or irregular opacities of anterior lens and cornea; systemic lupus erythematosus-like syndrome.

Dosage: Dosage must be individualized according to the degree of mental and emotional disturbance, and the smallest effective dosage should be determined for each patient. In adults with depressive neurosis the usual starting dosage is 25 mg I.D., and the dosage ranges from 10 mg I.D. to 6 I.D. in milder cases to 50 mg I.D. or q.i.d. for more severely disturbed patients; the total daily dose ranges from 75 mg to a maximum of 200 mg.



75-360

SANDOZ

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Renal Transplant Deaths Held to 3% in Paris

By SUE WYMELENBERG
Special Tribune Correspondent

BOSTON—"A series of small improvements in patient treatment" is enabling the Necker Hospital in Paris to reach good survival figures for kidney transplants, Dr. Jean Hamburger told Medical Tribune in an interview during the week he spent as visiting physician-in-chief at the Peter Bent Brigham hospital here.

Dr. Hamburger, who is chief of nephrology at the Necker, said that at his hospital, the most important factor in attaining better survival rates "besides good clinical follow-up—is a series of tests which permits more exact and more lucid treatment of each patient."

"Patients are no longer dying when

they reject a kidney. In the last two years we have had only a 3 per cent death rate in transplants overall."

Almost one-third of the approximately 350 renal transplants performed yearly in France take place at the Necker, although there are some 25 hospitals throughout the country that also do the procedure.

120 Hemodialysis Centers

Hemodialysis is available to patients at 120 centers, most of which are hospital based. The dialysis centers are connected by a teletype system; if a patient cannot be accommodated by one, the system will locate an available bed at another. Treatment results from each center are computerized and generally available to all hospitals.

As in the United States, there is an acute shortage of transplantable kidneys, not only in France but in all of Europe, Dr. Hamburger noted, adding that he is hopeful that the recently organized inter-European kidney exchange will be effective in making more available.

A problem more difficult to solve, he observed, is the shortage in France of medical teams trained to perform transplants.

"In France we now do about one transplant a day; we would like to be able to raise that number to about 1000 a year."

A useful breakthrough in the treatment of renal failure, he reported, is the development of an artificial kidney which uses a new type of mem-

brane. The membrane is much more permeable for molecules in the middle weight range and accomplishes a complete dialysis in one-half the time present equipment requires, "with reasonably good results."

The new membrane is made of polyacrylamide and Dr. Hamburger described its performance as "quite different;" a possible solution to the twin problems of patient load and high cost that now plague the treatment.

Patients prefer it, of course, he said, because of the shorter time required. So far 12 patients have been treated on the new unit, and the first patient now had had two years with it.

At the Necker Hospital, the ever-present problem of graft rejection is being attacked from several different directions, the French nephrologist said.

Wednesday, June 18, 1975

MEDICAL TRIBUNE

Current Opinion

What's In A Word? or Guilt By Definition

By DR. JONATHAN O. COLE

Psychiatrist, McLean Hospital, Belmont, Mass.,
and Lecturer in Psychiatry, Harvard Medical School,
excerpted from Massachusetts J. Mental Health, Winter, 1975.

LET'S TAKE BED-WETTING as an example for consideration of the ramifications. One behavior modification approach to bed-wetting is the use of an alarm system which is triggered when the patient urinates in bed. Activation of the loud alarm scares the subject and presumably conditions him not to wet the bed. This sometimes works. Less drastic behavior modification techniques such as withholding liquids before bedtime and waking the subject up during the night to go to the bathroom may also help. Occasionally rare organic abnormalities are found which can be treated. In addition, certain drugs, particularly the tricyclic antidepressants, are clearly more effective than placebo in causing patients to stop wetting the bed. It is even possible that the bed-wetting is a symptom secondary to conflict within the family as a whole and it may well be that family therapy would be successful in some cases and that individual psychotherapy might be of use in others.

Part II

of programs of systematic reward and punishment on unwilling prisoners poses more of an ethical dilemma. However, it may well be that impartial boards of ex-prisoners, psychologists and investigators would find some programs of this sort far preferable to throwing the prisoner into solitary for a month.

Clockwork Orange Analogy

I, too, have read *Clockwork Orange*, but I have no reason to believe that current methods of behavior modification or rehabilitation are anywhere near to being developable or implementable to be able to produce the result described in that scientific fiction novel. When

Acceptable to Patient?

The main issue in attempting to cure bed-wetting is to figure out a treatment which works and which is acceptable to the patient, and several might have to be tried. As with other forms of behavior modification, the question can be raised as to the informed consent of the subject.

It seems likely that most people, including children who wet the bed, would rather not wet the bed and are therefore willing to go along with any reasonable approach to treatment. Assuming there are some individuals, adults or children, who do not wish to stop wetting the bed, they presumably are untreatable. However, society, manifested perhaps by an angry mother, will at some point force the individual who wishes to continue wetting the bed to handle his own laundry, sheet changing, etc., invoking another form of behavior modification, namely aversive conditioning. It may or may not work, particularly if it is not systematically applied.

and if behavior modification techniques reach that degree of precision and potency, the implicit ethical issues will have to be faced. Arguing by analogy or special example is always faulty, but I am tempted to note that the hero in *Clockwork Orange* a) might have preferred to have his behavior modified as against spending the rest of his life in prison or going to the electric chair and b) a good behavior modification program would have been aware of the onus. On the other hand, they are excellent drugs for treating schizophrenic illnesses and are also effective in reducing impulsive unstable behavior in some patients with marked frequent mood swings. To control this type of psychopathology, low steady maintenance doses of the drug are necessary. Episodic intramuscular injections are not appropriate.

The Prisoner With Anxiety

Similarly, diazepam or chlordiazepoxide or even the barbiturates are sometimes quite effective in treating both chronic and acute neurotic anxiety. When a prisoner is suffering from clear anxiety state which cannot be adequately handled by either counseling or environmental manipulation, then such drugs are appropriate. Antidepressants may well have a place in the treatment of mild to moderate depression in prisoners. Lithium carbonate has been reported to be quite helpful enough now; to block off study or application of newer approaches is to condemn us all to treatment by whim or belief and to return us to a prescriptive primitive level of psychiatric practice—and unevaluated practice at that!

tee on Social Welfare in Massachusetts which bans the study of psychotropic drugs in prisoners. The earlier draft of the bill sought to put severe limitations on the use of psychotropic drugs in prisoners.

Lack of Studies

In short, I believe that psychotropic drug use in prisoners can occasionally be most appropriate although the physician or psychiatrist prescribing drugs for prisoners must be wary about the abuse potential of some of these drugs. Furthermore, there have been almost no systematic studies of the effectiveness of psychotropic drugs in treating various symptoms and behavioral adjustment problems in prisoners. Such research badly needs to be done.

Again, within any prison, I am sure there is a group of individuals who feel very uncomfortable within themselves and very unsure of their ability to maintain stability or well organized behavior either within the prison or later in the community. Such individuals often want help and it is possible that present or future drugs will be able to provide it. Some proportion of criminality is likely to be secondary to some type of abnormality in brain function or to the presence of intense emotions with which the patient's personality cannot cope.

Need for Research and Review

I am not arguing for the promiscuous testing of all sorts of new psychotropic drugs on defenseless prisoners. I am in favor of well designed, well planned and thoroughly reviewed research projects—the review must contain institutional review at the prison with prisoner participation—which result in the completion of sound research projects that provide meaningful information about the effects and usefulness of psychoactive drugs in prisoners. Such studies should be of benefit not only to the prisoners participating but ultimately to prisoners in general.

In conclusion, I'd like to pray for sanity, restraint and judgment in both the use and the interpretation of the phrases "behavior modification" and "psychoactive drugs." Please don't use these words as epithets . . .

" . . . to kill off a treatment approach because someone somewhere sometime might conceivably be given it against his will or punitively is to do malicious harm to us all . . ."

"psychoactive drugs." Neither the words nor the treatments denoted by them (justly or unjustly) are either necessarily bad or good. Please don't use these words as epithets. Both drugs and behavioral techniques can do a lot of good.

I am also pleading that treatments be evaluated on the basis of their efficacy and used if they work and condemned if they don't. They should be condemned also if they do more harm than good. But to kill off a treatment approach because someone somewhere sometime might conceivably be given it against his will or punitively is to do malicious harm to us all. Psychiatric treatments are not nearly effective enough now; to block off study or application of newer approaches is to condemn us all to treatment by whim or belief and to return us to a prescriptive primitive level of psychiatric practice—and unevaluated practice at that!

Pain: a call to action.



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See dosage and administration section of Brief Summary.

Whenever an APC/narcotic is indicated.

EX 6252

Percodan®

Each yellow, scored tablet contains 4.50 mg. oxycodone HCl (U.S.P.) and 32 mg. aspirin (U.S.P.).

INDICATIONS: For the relief of moderate to moderately severe pain.

CONTRAINdications: Hypersensitivity to aspirin, aspirin, salicylates, or sulfonamides.

WARNINGS: Drug Dependence: Percodan can produce drug dependence of the morphine type if used excessively or for long periods of time. Frequent or prolonged use of Percodan may lead to drug dependence and should be discontinued as soon as possible upon repeated administration of Percodan, and it should be discontinued and administered with the same degree of caution appropriate to the use of other oral non-narcotic analgesics. Like other oral non-narcotic analgesics, Percodan is subject to the Federal Controlled Substances Act.

Usage in Children: Federal Controlled Substances Act.

Usage in Pregnancy: Use of Percodan in pregnancy has not been satisfactorily related to possible adverse effects on fetal development. Therefore, Percodan should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

Usage in Children: Percodan should not be administered to children.

Usage in Patients: Percodan should be used with caution in the presence of physical signs of drug dependence.

PRECAUTIONS: Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. These drugs are contraindicated in the presence of head injury or pre-existing increased intracranial pressure which may obscure the clinical course of head injury.

Acute abdominal conditions: The administration of Percodan or other narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

Caution in Patients: Percodan should be given with caution in certain patients such as the elderly, debilitated, convalescent, those with impaired hepatic or renal function, hypertension, Addison's disease, and peptic ulceration or urethral stricture.

Percodan has been reported to damage the liver when taken in massive amounts (over 1000 mg. daily).

ADVERSE REACTIONS: The most frequently observed adverse reactions include lightheadedness, dizziness, sedation, nausea and vomiting. Some of these adverse reactions may be alleviated if the patient lies down.

Other adverse reactions include euphoria, dysphoria, constipation and pruritis.

DOSE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of severe pain or in those patients who have become tolerant to the analgesic effect of narcotics.

The usual adult dose is one tablet every 6 hours.

DRUG INTERACTIONS: The CNS depressant effects of Percodan may be additive with other CNS depressants. See WARNINGS.

Aspirin may enhance the effect of anticoagulants and inhibit the effect of oral contraceptives.

MISUSE OF OVERDOSE: Signs and Symptoms: Severe respiratory depression, hypotension, miosis, respiratory depression, cardiac arrhythmia, and circulatory collapse, cardiac arrest and death may occur. In severe overdosage, respiratory depression may be the most prominent effect of narcotics.

Management: In the event of an overdose, the patient should be kept under close observation and resuscitated if necessary.

Resuscitation should be given to the establishment of a patent airway and the initiation of assisted or controlled ventilation. The correct technique of resuscitation, including oxygen, resuscitation drugs and resuscitation equipment, should be administered, preferably by the intravenous route.

Artificial respiration should be continued as long as possible.

Artificial respiration should be discontinued if resuscitation efforts are prolonged.

Artificial respiration should not be discontinued in the absence of clinically significant respiratory or cardiovascular depression.

Artificial respiration, fluids, vasopressors and other supportive measures should be employed as indicated.

Resuscitation may be useful in resuscitating anesthetized drug.

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INDICATIONS

Hypertension and edema.

CONTRAINDICATIONS

Anuria; hypersensitivity to this or other sulfonamide-derived drugs. The routine use of diuretics in an otherwise healthy pregnant woman with or without mild edema is contraindicated and possibly hazardous.

WARNING

Use with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte imbalance may precipitate hepatic coma.

Thiazides may be additive with other drugs and may potentiate the actions of other drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions are more likely to occur in patients with a history of allergy or bronchial asthma. The possibility of cross-sensitivity with other sulfonamides, e.g., lupus erythematosus has been reported.

Usage in Pregnancy

Usage of thiazides in women of childbearing age requires that the potential benefits of the drug be weighed against the possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

Nursing Mothers

Thiazides cross the placental barrier and appear in cord blood and breast milk.

PRECAUTIONS

Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals. Observe patients for signs of fluid or electrolyte imbalance (hypotension, hypovolemia, hypotension, and hypocalcemia). Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral nutrition. Diuretic such as digitalis may also influence serum electrolyte levels. These are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbance such as nausea or vomiting.

Hypokalemia may develop with thiazides as with any other potent diuretic, especially during brisk diuresis, when severe cirrhosis is present, or during concomitant administration of steroid or ACTH.

Interference with adequate oral intake of electrolytes will also contribute to hypokalemia. Digitalis therapy may exaggerate metabolic effects of hypokalemia, especially with reference to myocardial activity.

Adverse REACTIONS

Gastrointestinal—anorexia, gastritis, irritation, nausea, vomiting, cramps, diarrhea, constipation, headache, dizziness, pancreatitis.

Central Nervous System—dizziness, headache, paresthesia, vertigo, tinnitus, photophobia, rash, urticaria, nervousness, angina, Stevens-Johnson syndrome, and other neurologic reactions.

Hematologic—leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia, cardiovascular—hypertension, hypotension may occur and may be potentiated by al�itol, barbiturates, or narcotics.

Other—hyperglycemia, glycosuria, hypercalcemia, changes in blood sugar.

Transient elevations in plasma calcium may occur in patients receiving thiazides, particularly in those with hyperparathyroidism. Pathological changes in patients on prolonged thiazide therapy have been reported in a few patients.

Hypoglycemia may occur or frank gout may be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Hypoglycemia may also manifest during thiazide administration.

Thiazide drugs may increase the responsiveness of the heart to epinephrine. The antihypertensive effects of the drug may be enhanced in the post-sympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

If norepinephrine indicates onset of progressive renal impairment consider withholding or discontinuing diuretic.

Thiazides may decrease serum PBI levels without evidence of thyroid disturbance.

Adverse REACTIONS

Gastrointestinal—anorexia, gastritis, irritation, nausea, vomiting, cramps, diarrhea, constipation, headache, dizziness, pancreatitis.

Central Nervous System—dizziness, headache, paresthesia, vertigo, tinnitus, photophobia, rash, urticaria, nervousness, angina, Stevens-Johnson syndrome, and other neurologic reactions.

Hematologic—leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia, cardiovascular—hypertension, hypotension may occur and may be potentiated by al�itol, barbiturates, or narcotics.

Other—hyperglycemia, glycosuria, hypercalcemia, changes in blood sugar.

Constitutive literature before prescribing.

CIBA Pharmaceuticals Company, Division of CIBA-GEIGY Corporation, Summit, New Jersey 07901

C I B A

Wednesday, June 18, 1975

MEDICAL TRIBUNE

The Only Independent Weekly Medical Newspaper in the U.S.

Medical Tribune

and Medical News
Published by Medical Tribune, Inc.

Damn the Cost—Full Speed Ahead!

THE DEPARTMENT of Health, Education and Welfare, now busily formulating economic regulations on prescription practice, is the same agency which has just acknowledged that government officials at various levels are responsible for one billion dollars of erroneous welfare payments in just one year.

This is independent of cheating by recipients. "We don't know how much cheating there is because it hasn't been studied," said a welfare advisor to H.E.W. Secretary Caspar Weinberger, "but it is probably well in excess of 15 per cent and may be close to 30 per cent." Quite a difference from the previous claim of less than one per cent.

Thus, error accounts for misuse of about one billion dollars and cheating for up to three billion.

Previously MEDICAL TRIBUNE had noted editorially H.E.W.'s claim that savings of the order of one-three hundredths of the above waste justified regulatory changes in doctors' prescription practices. They did not note that these hypothetical "savings" had omitted administrative costs and had never had a test of feasibility. It is now

clear that proper calculations must also add both expenses for surveillance and administrative errors; also to be added will be the burden of cheating. The ultimate cost to government and patients of H.E.W.'s economic control of prescription drug practice can be an economic catastrophe that will further significantly escalate the cost of health care.

It escapes us to why a government department under which errors of the magnitude of billions occurred is qualified to alter prescription practices on economic grounds and on the flimsiest of unproven and untested claims. It is incomprehensible why bureaucrats focus with diligence and intensity on hypothetical, improbable "savings" of millions while errors costing billions occur year in and year out, under their noses, within their jurisdiction and under their responsibility.

Incomprehensible? Perhaps not; "money saving" stories, even if fables, make for headlines if not for good economics. Costly? Yes, for our patients and the public. It would seem that when political capital can be coined out of health care costs, it's "damn the cost, full speed ahead." A.M.S.

Management of Hypertension in Australia

IT IS AN enlightening experience to read about the "Changing Concepts in the Management of Hypertension" as reported in a recent issue of *The Medical Journal of Australia*. Dr. Priscilla Kincaid-Smith and her colleagues at the Royal Melbourne Hospital and the department of medicine of the University of Melbourne have reviewed their management regimes in an active hypertension clinic attended by 591 patients over a 13-year period, from 1961-1974. They report marked changes in their pattern of use of hypertension agents during that interval.

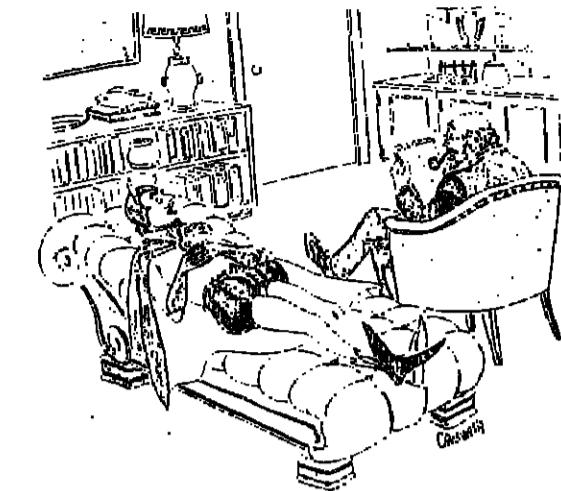
What has remained constant has been the use of thiazides in almost all cases throughout that period. There was "a swing away from the sympathetic and ganglion-blocking agents to methyldopa" in the interval between 1961 and 1967. What happened in the next seven years was "a swing towards two new methods of treatment—namely beta adrenergic blocking agents and peripheral vasodilators."

Clonidine has only recently been approved in the U.S. for the treatment of hypertension; by this time its exhibition at the Royal Melbourne Hospital is in decline. The use of a beta adrenergic blocking agent for the treatment of hypertension is still not approved in the United States; in Australia, more than one beta adrenergic blocking agent is legally available for the treatment of hypertension.

Actually, V.A. physicians already have substantive access to a salary "bonus" in that, according to regulations, they may treat private patients and receive supplemental income for teaching at a university affiliate, so long as this does not adversely affect the treatment of veterans.

In my opinion, job satisfaction and personal dignity can be more important to an individual than a high income per se, within or outside of the V.A. I feel that the most important factor lacking in the V.A. hospital system is true peer review of a physician's performance, particularly that of the service chiefs.

The resolution recently submitted by the Idaho delegation of the A.M.A. urging that federal hospitals be required to meet the same standards as voluntary hospitals, including peer review, deserves the utmost consideration.



"For that matter, what makes you think you're a psychiatrist?"

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LETTERS TO TRIBUNE

The Publisher's Blast

I have been associated with MEDICAL TRIBUNE for twelve years and, if it were not for my fundamental responsibility, I would ask to be removed from the mailing list in view of the article recently published entitled "Questions and Answers on Vibrators."

As an editor, you know that the publisher of MEDICAL TRIBUNE has long favored an open-minded attitude on the reportage of scientifically valid articles and material on sex education. You must also be familiar with the fact that MEDICAL TRIBUNE has an editorial credo. Nowhere have I found a basis in its credo for that particular article.

I must say that the only thing the vibrator has succeeded in doing for me is to shake me up in respect to some of the material carried in MEDICAL TRIBUNE under the aegis of the right of the editors to a free press.

ARTHUR M. SACKLER, M.D.
New York, N.Y.

tion in my opinion. I believe that most professionals enter V.A. service with the primary desire of serving veterans. I further believe that if potential V.A. physicians could be assured that their expertise in this direction would not be thwarted by lesser or nonqualified administrative "superiors," the problem of V.A. physician recruitment would be largely solved.

FOLKE BECKER, M.D.
Birmingham, Alabama 35205

Symposium Syndrome?

I have just read the editorial entitled "Ethics and Experiments" (MT, May 14). I have no quarrel with the basic philosophy expressed. However, I am disturbed by what seems to be a proliferation of unnecessary complicated approaches to obvious problems and their management.

There is a certain hyperbole in the first sentence, "In the few years since its establishment in 1969, the Hastings Institute of Society, Ethics and Life Sciences has increasingly served as an interdisciplinary catalyst." It went on to state that they have mobilized the thoughts of physicians, biologists, philosophers, lawyers, sociologists and others to consider the nature of ethics.

This proliferation is probably the Symposium Syndrome, a diagnosis invariably associated with episodic Acute Committeeitis. We might state a simple formula that:

Ethics=Eternal Verities
Technological Bureaucracy.

After mulling this over a bit, we might take the recently exhumed committee word; Thanatology, and replace it with a more direct phrase, Study of Death.

CHARLES E. MACMAHON, M.D.
Seattle, Wash.

P.S. If the formula:
Ethics=Eternal Verities
Technological Bureaucracy
comes out a fraction, we're in a hell of a fix.

N.B. The reduction of evaluation of behavioral values to a formula was suggested by Henry James—
Self-esteem=Success
Pretensions

Dr. Warren Honored at Bunker Hill Ceremony

Continued from page 1
cessful treatment of smallpox, he "acquired a high reputation among the faculty," according to *Harper's Encyclopedia of United States History*. In his practice, he relied primarily on the leeches, purgatives, cupping devices and herbs that then constituted the physician's armamentarium.

However, Dr. Warren's fame rests on his role as one of the prime organizers of the revolt against British rule through the committees of correspondence in each community.

He was a protege of Samuel Adams, chief strategist of the colonists cause. At a meeting at Dr. Warren's house, in September, 1774, Samuel Adams, James Otis and others discussed the formulation of demands in Boston town meeting that "forced the British government to prepare for war with Massachusetts," historians later said.

Aided by Doctor Brother

In all this Dr. Warren had the help and collaboration of his physician brother, Dr. John Warren, a participant in the Boston Tea Party. Dr. John Warren later drew up plans for Harvard Medical School, became its first professor of surgery and anatomy, and helped found the Massachusetts Medical Society.

In September, 1774, Dr. Joseph Warren personally drafted the "Suffolk Resolves," which attacked the coercive laws under which the British governor had closed the port of Boston and confiscated local taxes. This was a daring open challenge to British rule. It was, historians later said, "a complete declaration of war against Great Britain." And Dr. Warren, as soon as it was passed, handed a copy of it to Paul Revere who personally rode to Philadelphia to deliver it to the rebellious Continental Congress which adopted it after much debate.

Dr. Warren played a leading role in one of the pre-Revolutionary uprisings that he and Sam Adams kept churning up. On the occasion of the fifth anniversary of Boston Massacre, Dr. Warren delivered the annual oration. British officers filled the Old South



DR. JOSEPH WARREN

Meetinghouse expecting to "beat up abe," in Samuel Adams' phrase. But Adams welcomed them civilly and then Dr. Warren, clad in a "Ciceronian toga, mounted the black draped pulpit" surrounded by the most violent of the revolutionaries, the Adamses, Cooper, John Hancock, and the Boston Selectmen.

Dr. Warren concluded his oration without provoking a riot by carefully not using the words, "bloody massacre." But when he finished, Samuel Adams jumped up, praised and thanked Dr. Warren and proposed another oration for the following year "to commemorate the bloody massacre!"

Whereupon the British officers jumped up, crying "O fie, O fie," and waving their arms indignantly. At that moment a British regiment was passing by, its drums rolling. Some of the citizenry thought the British were crying "Fire" and made for the doors but a great many more thought they were about to be slaughtered in a British trap—and they went out the windows.

Dr. Warren presided over the Massachusetts Provincial Congress in 1774 and chaired its committee of safety. He was commissioned a major general in the Massachusetts militia.

When Gen. Thomas Gage, the British governor, sent troops to arrest Samuel Adams and John Hancock and to destroy the military stores of the militia at Concord, Dr. Warren's friends informed him of the troop movements and he had previously arranged for his infant son's education. A Masonic lodge erected a pedestal in 1794 on the spot where Dr. Warren's monument was built on the same spot. The latter was unveiled on June 17, 1857.

Dr. Warren was only 34 years old at the time of his death.



Bunker Hill 1775 by Trumbull

US Bicentennial IOC

The 10-cent stamp commemorating the 200th anniversary of the Battle of Bunker Hill, issued on June 17. The design features the dying Dr. Warren; it is based on a detail of the famous painting by Trumbull on page 1.

Helped Cover Retreat

Finally when the Americans did indeed run out of powder, Colonel Prescott ordered his men to pull back. Dr. Warren stayed behind to cover their retreat, then started to move back himself. At that point, according to *Harper's Encyclopedia*, "an officer of the British army who knew him called out to him by name to surrender, at the same time commanding his men to cease firing. As Warren turned, attracted by the voice, a bullet penetrated his brain and he fell dead."

The Continental Congress voted him a monument and resolved to pay for his infant son's education. A Masonic lodge erected a pedestal in 1794 on the spot where Dr. Warren's monument was built on the same spot. The latter was unveiled on June 17, 1857.

Dr. Warren was only 34 years old at the time of his death.

Patient Role Urged In Antitumor Drug Use in Pregnancy

Medical Tribune Report

NEW ORLEANS—Let the patient participate in the decision as to whether antitumor drugs, which are highly teratogenic, are to be administered during pregnancy.

This was the advice of Dr. Walter B. Cherny, director of post graduate education at the Good Samaritan Hospital, Phoenix, to physicians attending the New Orleans Graduate Medical Assembly.

"People with malignancies do get pregnant," he reminded. "We know that the risk factor of fetal abnormalities runs as high as 45 per cent to 50 per cent in some of the cancer drugs."

"The mother should be told this. She should know, and her wishes must be considered."

Dr. Cherny's own view is: "If you have to use it, do it." But if a drug is not essential to the pregnant patient's well-being, avoid it.

He noted that most of the common medications, including antibiotics, cold remedies, and antihistamines, have some teratogenic qualities. But physicians should not over-react and go to the extreme of withholding essential medicines. "Balance the risk," said Dr. Cherny, "If a drug is essential, it ought to be used."

At the same time he discouraged the prescription of drugs just because they are available.

"Take patient discomfort, vomiting. The condition is not life-threatening. In this circumstance, don't use anti-nausea drugs," the obstetrician advised. "And in mild infections, don't give antibiotics."

Regular Prescription of Iron

He added that the only chemical which should be prescribed regularly is the one the body needs but cannot store—iron. "A pregnant woman needs large amounts of iron. It is innocuous, except in gross overdoses."

There is a serious question, he said, as to whether a pregnant woman needs prescription vitamins.

He warned against a tendency to prescribe drugs "just to make the patient feel better."

Dr. Cherny advised aggressive measures against the development of toxemia.

He told the New Orleans Graduate Medical Assembly the condition—signs of which are rising blood pressure, excessive weight gain, puffiness of the face, eyes and fingers, kidney damage—is not an indication for immediate delivery, he said. "You don't have to subject the baby to immaturity."

Onset of toxemia "is an indication that the patient has lost her ability to cope with physiological stress."

"Be aggressive in guarding against the condition. Watch for elevating blood pressure, rapid weight gain, kidney damage, a special kind of swelling that is not just edema. Don't confuse puffiness of the face and fingers with the usual swelling of ankles and feet."

He said the best safeguard is to keep the patient in good health.

Arteriosclerotic Basis Denied For Bulk of Senile Dementia

Continued from page 1
to be "essentially identical" to pre-senile dementia of the Alzheimer type.

He estimates that 65 per cent or more of all senile dementia patients have the Alzheimer form—and therefore thinks that therapy directed at treating blood flow problems is totally useless in this majority.

Another highly significant research finding, in his view, is the evidence that the brains of "normal" elderly people can show the same three lesions observed in senile dementia: nerve cell loss, neurofibrillary tangles composed of "twisted tubules," and senile plaques.

"Physically, the lesions are very much the same," Dr. Terry said. "In demented patients, they are exaggerated in number, but they are the same changes as those found to a much lesser extent in people who seemed to be functioning normally at the time of their death in the seventh or later decade."

Link to Psychometric Deficiency

Furthermore, the investigator pointed out that a close, positive correlation has been found by other research groups between concentrations of plaque in the cerebral cortex and the degree of psychometric deficiency shown by the patient.

Dr. Terry cautioned, however, that there is still no consensus as to whether the process that causes the rapid decline in mentality seen in dementia is the same process responsible for the "more or less steady decline at a variable rate" seen with advancing age and called "benign memory loss."

One process may be superimposed on the other, he said. And why the decline should be so "tragically severe and swift in some and marvelously slow in others cannot yet be explained."

Even the question of hereditary influence remains uncertain. There is some evidence, Dr. Terry observed, that "it helps to come from the right lineage" since the risk among first-order relatives of patients with senile dementia is significantly increased, and presenile dementia apparently occurs in some families with an autosomal dominant mode of inheritance. But most cases of senile dementia are sporadic, he said.

Sociologic Impact Stressed

Stressing the sociologic impact of senile dementia, Dr. Terry cited two statistics: nearly 11 per cent of the U.S. population over the age of 65 is said to have some degree of the disorder, and about 4.5 per cent of these elderly people are severely demented.

This is a "huge public health problem that has gone largely unrecognized," he said. Public health statistics are "grossly misleading" since senile dementia is not listed among 200-plus common causes of death and is almost never entered on death certificates yet "probably accounts directly or indirectly for some 120,000 deaths annually."

All three of the major brain lesions found in senile dementia are being

studied by Dr. Terry and co-investigators at Einstein.

To determine nerve cell loss, for example, they are now utilizing a new computerized and automated nerve cell counter. This equipment, they believe, promises to yield data far more efficiently and accurately than did previous "hand counts."

Research in their laboratory and elsewhere on the neurofibrillary tangles has shown that the fibrillary material first described by Alzheimer in 1906 is composed of "abnormal" twisted elements which average 22 nm. in outside diameter and narrow about every 80 nm., Dr. Terry said. These have been found to date only in the human brain—and only in the brains of the elderly or of patients with senile dementia or a few other pathologic conditions including postencephalitic Parkinsonism and Guern-Parkinsonism dementia.

Normal microtubules have a slightly wider diameter and are known to be made up almost entirely of tubulin, a protein consisting of an alpha-monomer (molecular weight 56,000) and beta-monomer (molecular weight 53,000).

Dr. Terry pointed out that since the normal microtubule or neurotubule resembles the twisted tubule in many respects, investigation is underway to determine whether the abnormal analog is a modification of normal tubulin or an entirely new protein.

May Be Neurofilaments

There is a "real possibility," he believes, that such twisted tubules are not neurotubules but rather a pair of helically wound neurofilaments. In its normal state, the neurofilament has a diameter of 10 nm., is ultrastructurally different from the neurotubule, and has in the human being a molecular weight of 53,000.

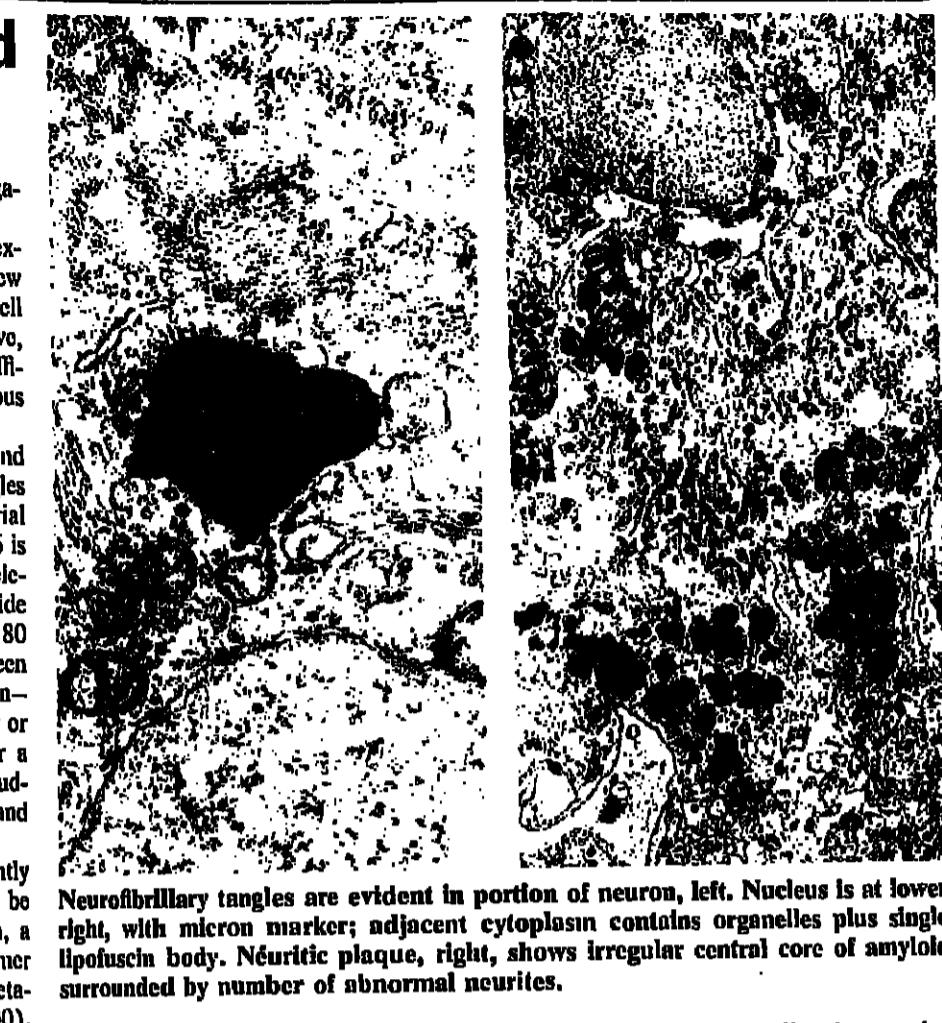
"If the twisted tubule is a modification of one or another of these proteins," he commented, "then we must look to the way in which it was modified. This might result from abnormal oxidation or perhaps by binding with a metal such as aluminum."

Experiments with certain animals have demonstrated that injection of aluminum into areas of the brain or spinal fluid will cause formation of neurofilamentous aggregates as contrasted with the neurofibrillary tangles seen in man, Dr. Terry said. Also, he noted that some investigators have reported finding abnormally high aluminum concentrations in the brains of patients with the Alzheimer type of dementia.

Tracing the modification to oxidation would mean that antioxidants could be tried therapeutically, Dr. Terry continued. This might give support to treatment with such antioxidants as vitamin E. On the other hand, if modification is due to a metal it would be logical to try a chelating agent.

"But in either case," he said, "we would have some rationale for treatment instead of trying every compound on the shelf as is now often the practice. Too frequently, in fact, drugs are given without even making an assessment."

Another project is the making of peptide maps of normal tubule protein, normal neurofilament protein, and twisted tubule protein so that the three can be compared.



Neurofibrillary tangles are evident in portion of neuron, left. Nucleus is at lower right, with micron marker; adjacent cytoplasm contains organelles plus single lipofuscin body. Néuritic plaque, right, shows irregular central core of amyloid surrounded by number of abnormal neurites.

What about the senile plaques that are found in the brains of the normal elderly and young adults with Down's syndrome, and in significant numbers in the brains of patients with the Alzheimer type of dementia?

Dr. Terry noted that plaques have some overlap with the tangles. The axonal and dendritic endings that make up plaque are filled to a greater or lesser extent with twisted tubules. The intervening axon does not contain them. These neurites also contain many lysosomes and mitochondria.

Another component of plaque is amyloid—a fact, said Dr. Terry, that "gives rise to all sorts of thoughts about immune processes," since some investigators believe that one type of amyloid is made up of fragments of light chains of immunoglobulin.

Some investigators also consider amyloid deposits to be the primary change that leads to cortical destruction, producing both the plaque and neurofibrillary tangles. Dr. Terry disagrees with this view, stating his hypothesis that the presence of degenerative neurites in the plaque precedes the amyloid deposits. But in any case, he emphasized, amyloid from the plaque must be isolated and its nature determined.

"Changes in the immune system of aging organisms are currently of considerable interest," he said. "Certain aspects of immune systems decline with age while others actually increase in the sense that autoantibodies are more prominent in aged than in younger organisms, whether animals or man. The whole problem of loss of neurons with aging, for example, may possibly be one of autoimmunization."

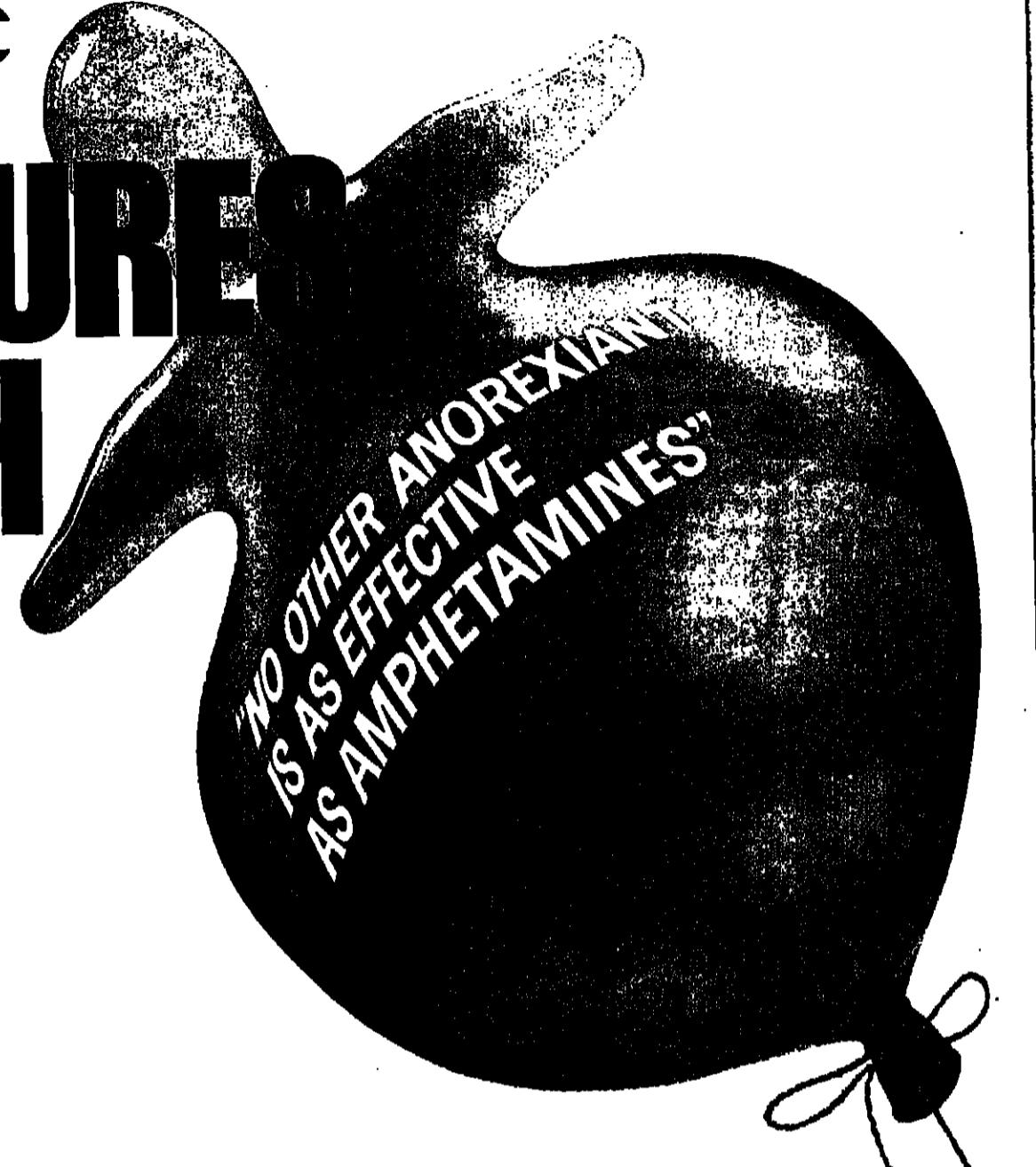
Several studies have already documented the presence in some aged animals and man of a circulating antibody.

antibody, he commented. If this antibody is labeled and put in contact with brain, young or old, "it reacts with neurons, thus showing that this is where the antigen is."

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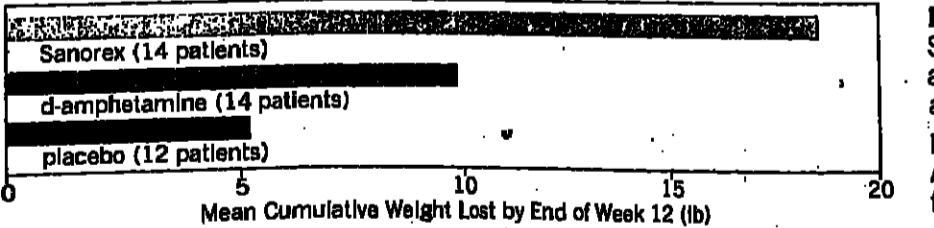
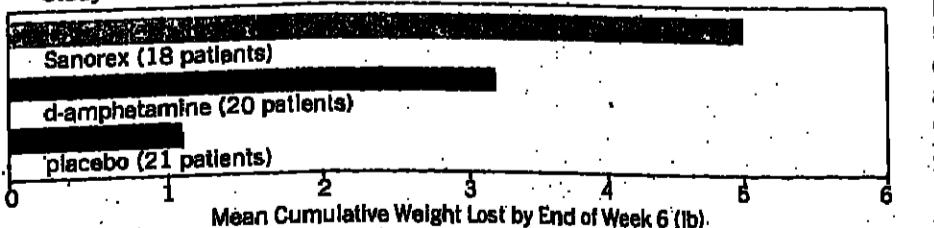
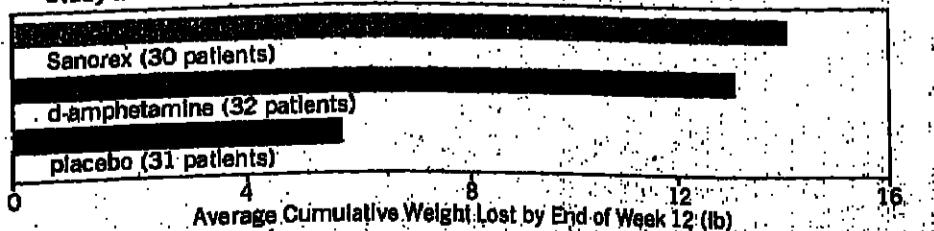
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Study I¹Study II²Study III³

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Different Chemical Structure

Sanorex is chemically unrelated to d-amphetamine—or any other "non-amphetamine" anorexiant available—and cannot be converted into an amphetamine-like substance in a biologic system.

Different Neurochemical Action*

Animal studies suggest that Sanorex, unlike d-amphetamine, does not interfere with norepinephrine synthesis.

Action of d-Amphetamine*

In animal studies, d-amphetamine (like food) activates afferent neurons leading to appetite centers in the hypothalamus. Resulting release of norepinephrine activates the receptor neurons. Unlike food, however, d-amphetamine also suppresses norepinephrine synthesis. Thus, increasingly larger doses of d-amphetamine become necessary to produce an effect.

Action of Sanorex*

After intake of food stimulates the release of norepinephrine from afferent neurons, Sanorex blocks its re-uptake without disturbing normal synthesis and release.

Simplicity and Flexibility of Dosage

Simple, one-a-day dosage is facilitated by 2-mg tablets (taken one hour before lunch). New flexibility (for the patient in whom 1 mg t.i.d. is preferred) is now facilitated by new 1-mg tablets (taken one hour before meals).

*The significance of these differences for humans is uncertain.

For Brief Summary, please see facing page.

SANOREX® (MAZINDOL)®

References:
1. Kornhaber A: Problems and current concepts in the treatment of obesity. Scientific Exhibit presented at the New York State Academy of Family Physicians, 25th Annual Scientific Convention, McAfee, NJ, May 10, 1975.
2. DeFronzo RA, Charkow LB, Cohen A: Double-blind, placebo-controlled evaluation of mazindol, dextroamphetamine, and placebo in obesity. *Am J Clin Nutr* 27:358-366, July 1973.
3. Verner J: Clinical considerations for malpractice patients: initial interview and effect of treatment in the office. Scientific Exhibit presented at the American Medical Association, Anaheim, Calif., 21st Annual Convention, June 14, 1973.

Indication: In exogenous obesity, as a short-term (a few weeks) adjunct in a weight-reduction regimen based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors.

Contraindications: Glaucoma; hypersensitivity or idiosyncrasy to the drug; agitated states; history of drug abuse; during or within 14 days following administration of monoamine oxidase inhibitors (hypertensive crisis may result).

Warnings: Tolerance to many anorectic drugs may develop within a few weeks. If this occurs, do not exceed recommended dose or discontinue drug. May impair ability to engage in potentially hazardous activities, such as operating machinery or driving a motor vehicle, and patient should be cautioned accordingly.

Drug Interactions: May decrease the hypotensive effect of guanethidine; patients should be monitored accordingly. May markedly potentiate pressor effect of exogenous catecholamines. If a patient regularly taking mazindol must be given pressor amine agents (e.g., levaterenol or sotalol) for shock (e.g., from a myocardial infarction), extreme care should be taken in monitoring blood pressure at frequent intervals and initiating pressor therapy with a low initial dose and careful titration.

Drug Dependence: Mazindol shares important pharmacologic properties with amphetamines and related stimulant drugs that have been extensively abused and can produce tolerance and severe psychologic dependence. Manifestations of chronic over dosage or withdrawal with mazindol have not been determined in humans. Abstinence effects have been observed in dogs after abrupt cessation for prolonged periods. There was some self-administration of the drug in monkeys. EEG studies and "liking" scores in human subjects yielded equivocal results. While no abuse potential of mazindol has not been further defined, possibility of dependence should be kept in mind when evaluating the desirability of including the drug in a weight-reduction program.

Usage in Pregnancy: In rats and rabbits an increase in neonatal mortality and a possible increased incidence of birth anomalies in rats were observed at relatively high doses. Although these studies have not indicated important adverse effects, the use of mazindol in pregnancy or in women who may become pregnant requires that potential benefit be weighed against possible hazard to mother and infant.

Usage in Children: Not recommended for use in children under 12 years of age.

Precautions: Insulin requirements in diabetics mellitus may be altered. Smallest amount of mazindol feasible should be prescribed or dispensed at one time to minimize possibility of over dosage. Use cautiously in hypertension, with monitoring of blood pressure; not recommended in severe hypertension or in symptomatic cardiovascular disease including arrhythmias. Adverse Reactions: Most common, dry mouth, tachycardia, constipation, nervousness, and insomnia. Cardiovascular: Palpitation, tachycardia. Central Nervous System: Overstimulation, restlessness, dizziness, insomnia, dysphoria, tremor, headache, depression, drowsiness, weakness. Gastrointestinal: Dryness of mouth, unpleasant taste, diarrhea, constipation, nausea, other gastrointestinal disturbances. Skin: Rash, excessive sweating, clamminess. Endocrine: Impotence. Changes in libido have rarely been observed. Eye: Long-term treatment with high doses in dogs resulted in some corneal opacities, reversible on cessation of medication; no such effect has been observed in humans.

Dosage and Administration: 1 mg, three times daily, one hour before meals, or 2 mg per day, taken one hour before lunch in a single dose.

How Supplied: Tablets, 1 mg and 2 mg, in packages of 100.

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One Man... and Medicine

ARTHUR M. SACKLER, M.D.,
International Publisher, Medical Tribune



For Arbitration In Malpractice Litigation

IT WAS a phone call for help. They are getting to be quite common these days. Emergencies appear to be escalating. This one was in reference to new legislation on malpractice insurance in the state of New York. The caller asked me to communicate with the Governor and members of the state legislature in opposition to the legislation. I knew of her reputation as a deeply concerned citizen; a fighter for rights of women, and a committed participant in consumer movements. There was no question as to her good faith. She is of the stuff that makes for good citizenship. Her name is Barbara Scaman, author of *Free and Female* and *The Doctors' Case Against the Pill*.

"Why are you so opposed to the new legislation?" I asked.

"Because it deprives patients, and particularly women, of protection they believe we should do about this problem?" "I can join you in supporting mediation panels for malpractice cases."

"I think," she said, "that such panels should have consumer representation."

"Agreed. But that representation should be by individuals who would be truly objective and recognize they represent the interest of both the patient as an individual and member of society. In any event, please send me the bill and the documents you have prepared so I can study them before acting..."

"Defensive" Medicine

The discussion was longer than the above and touched on some aspects which appear to be lost to many members of the public. I had mentioned to my caller the fact that malpractice liability suits and consumer pressures have been building up in such a way as to force physicians into "defensive" medical practice. The doctor is being increasingly confronted by an unfair dilemma of choices and placed in a "no win" situation.

"That's true," she said. "Well," I said, "there was a time when diethylstilbestrol was recognized as effective treatment for spontaneous abortion. In fact, the generic advocates of that day insisted it was more economical than progesterone which was also available. It was generally accepted that hormone therapy made possible fetal salvage. Thus, a woman who was miscarrying and was not treated with DES or progesterone could have claimed malpractice in a suit at that time. Today, on the basis of what you would like to see done, the physician who could have been subject to malpractice liability by his failure to treat the miscarrying woman then could now be subject to malpractice liability because he had acted in accord with prior good practice.

"As to the relationship of diethylstilbestrol and vaginal cancer, obviously this is an issue that is emotionally charged. While some may say that the DES may be related to vaginal cancer, others could rightly hold that a woman may have a spontaneous abortion because of a defective fetus; that DES treatment salvaged the defective fetus; that the mother had a child she may have desperately wanted, but that the hypothetical inherent defect which 'nature' may have been rejecting made its appearance ultimately in a malignancy in a 'salvaged' child."

"Well," she said, "what do you be-

Medicine on Stamps

Jean Martin Charcot



Born in 1825, the son of a Paris coach builder, Charcot became the founder of modern neurology. He is best known for his work in arthritis, begun during his student days, but he also contributed to research on poliomyelitis, hysteria, epilepsy, cerebral function, multiple sclerosis, and locomotor ataxia. A talented artist and music lover, strongly resembling Napoleon in appearance, he was the most colorful teacher of medicine of his day.

Text: Dr. Joseph Kler
Stamp: Minkus Publications, Inc., New York

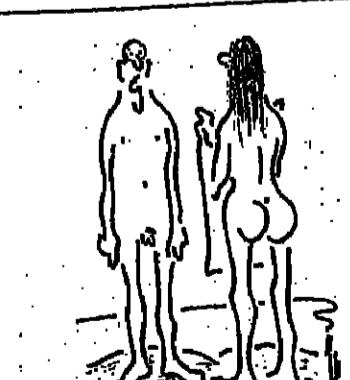
malpractice liability is less may be another. The physician certainly cannot be expected to subsidize medical care by taking money out of his life savings to either cover a liability suit or quadrupled insurance premiums. Regardless of any of the above, there is one thing that is clear but not comprehended by those who oppose corrective measures to the present epidemic of liability suits—the cost of court judgments and insurance premiums must be ultimately paid by one group, patients themselves.

A National Need

Restraint of the escalating cost of health care services is a national need even as the sick are entitled to sound medical practice as well as fair economic protection for the unfortunate victims of either negligence or accident. Reason, if necessary through arbitration or mediation, is essential if malpractice liability insurance is not to become an ever-growing burden for the majority of patients, as well as physicians. The interests of doctors and most of their patients are in the last analysis the same.

EPIGRAMS—Clinical and Otherwise

Doctors is all swabs.
Robert Louis Stevenson (1850-94)
Billy Bones



"How do you feel about acupuncture?"
© 1973, Medical Tribune, Inc.

Small Cerebral 'Pacemaker' Eases Pain in Madrid Trials

Medical Tribune World Service

MADRID—A miniaturized cerebral "pacemaker" has been employed here in clinical trials to relieve pain in a cancer patient and in an amputee suffering from phantom-limb distress.

In addition to analgesic uses, the device may also have broad application in brain research and in the treatment of epilepsy, according to its developers.

The apparatus was devised by a team at the Autonomous University of Madrid headed by Dr. José M. Rodríguez Delgado, formerly of Yale. It consists of a plastic-coated disk containing integrated circuits and components, 40 mm. in diameter by 15 mm.

thick, implanted under the scalp, with six electrodes reaching into selected brain sites.

The coin-size pacemaker operates without batteries or external wiring. It receives power from radio waves that are picked up by a small portable transformer carried by the patient, allowing for two-way flow between the brain and a computer or control panel. The brain may be monitored in bipolar recordings, while stimulation



A subject equipped with an earlier, bulkier version of the brain stimulator developed by Dr. José M. Rodríguez Delgado's Madrid team.

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Wholesome and unadorned young beauty impresses the eye with its natural distinction. Among medicinals, such natural distinction will be found in SENOKOT Tablets/Granules.

Standardized senna concentrate has two claims to natural distinction. In SENOKOT Tablets/Granules, it is standardized for uniform action. And it is prepared from the de-seeded pod of *Cassia acutifolia*, discarding the leaves that contain coarse resins.

Virtually color-specific, SENOKOT Tablets/Granules provide gentle, predictable overnight laxation, usually without side effects at recommended dosage levels. As regular elimination is established, dosage can be reduced gradually and eventually discontinued.

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may be provided to induce or restrain electrical activity.

According to Dr. Delgado, the pacemaker constitutes an improvement over "first generation" models that he used in the treatment of pain, thanks to its reduced size and freedom from encumbering wires. It also avoids the discomfort and possible infection resulting from sockets and leads piercing the scalp.

In treatment of the patient with phantom limb, programmed stimulation of the septum led to relief of previously intractable pain and diminished the patient's hostility. While final evaluation will require long-term follow-up, this case has demonstrated to the Delgado team the feasibility of transdermal, remotely controlled, programmed stimulation of the human brain for therapeutic purposes.

Regarding the possibility of treatment of epileptics, Dr. Delgado theorizes that a pacemaker-radio system may be devised in conjunction with a portable computer and power source that would continuously monitor brain activity and supply preventive stimulation when an attack was imminent.

Quadriceps Surgery In Children Simplified

Medical Tribune World Service

KYOTO, JAPAN—Over the past eight years, diminution of the quadriceps due to thigh injections during infancy has been cured with "relatively simple surgery" in 50 patients aged five to 12, at the Nishitaga National Sanitorium.

According to surgeons there, the operation involves cutting out the affected muscle and separating muscle adhesions.

Conventional surgery had called for extending the tendon besides removing the affected muscle, the surgeons told the *Japan Times*. Moreover, the psychological impact of the new treatment, which leaves only one scar, is less for young patients, they said.

"Postsurgery surveys revealed that all the cases have nearly regained full capacity to walk," the report from the sanitorium revealed. Citing the case of an 11-year-old girl operated on eight years ago, the Japanese surgeons said that before the operation, she could bend her knees only 30 degrees, but now she can bend 130 degrees and walk without difficulty.

Wednesday, June 18, 1975

MEDICAL TRIBUNE

Aerosol Sniffers 'Playing Russian Roulette'

Medical Tribune Report

NEW ORLEANS—Teenage spray can propellant sniffers are playing Russian roulette and ought to be so informed.

Dr. Leo G. Horan, chairman of the health services center at the University of Louisville, made these observations to physicians attending the New Orleans Graduate Medical Assembly.

New York's troubled financial terrain has long been ready for a political bombshell. The shrewd speaker of the lower house of New York legislature, Stanley Steingut, has just exploded it. He has enlisted the advice of the always formidable Ralph Nader, and he has found a model for New York State to follow in all places, the populist state of North Dakota.

It's a far cry from the plains of Bismarck to the canyons of Wall Street. Nevertheless, New York, banker to the world and therefore busted, is taking as its model the "operation bootstrap" that the farmers of North Dakota devised during the farm depression of the otherwise prosperous 1920s. The Bank of North Dakota is the only state-owned bank in the country, and it operates at a profit. Its president, H. L. Thorndal, testified at the hearing called by Speaker Steingut that this unique institution, founded with a \$2 million investment, has earned a cumulative profit of \$83 million in the 56 years of its existence. Last year alone, Mr. Thorndal stated, the Bank of North Dakota reported \$16 million of profit to the state legislature.

Nader invited New York State to follow where North Dakota has led. Speaker Steingut's staff advisors discovered that their original guesstimate that the state, though busted, has a deposit float of \$3 billion in banks throughout the state ready for redevelopment on the North Dakota model is low. Speaker Steingut also asked me to furnish a recommendation for this emergency, and I will summarize it in this space next week.

Do you think there is any real possibility that New York City's credit problems could be solved by selling small bonds to people through the Off-Track Betting Offices? My patients believe this will happen.

New York Physician

I don't. Average people—even betting folk—tend to be smarter than banks. If even banks don't want to be stuck with any more NYC garbage, why should people?

Can mortgage rates be expected to go down? I should like to build a vacation home in New England, but the mortgage rates I'm quoted make it ridiculous.

Boston Physician

I fear mortgage rates are headed up again. Their high level is only one reason why you're right in regarding building costs as ridiculous. Because you're right, buying makes better sense than building.

Elliott Janeway regularly answers MEDICAL TRIBUNE readers' questions.

per cent of the propellants from bags or balloons. The death rate has declined from the peak years because there is a trend away from drug addiction and toward the use of alcohol.

Route to Drug Addiction

Dr. Horan said sniffing is a route toward drug or alcohol addiction. "It is essential that young people know the hazards," he added. They should be informed in the homes and at Boy Scout meetings that they are playing Russian roulette.

He said eventually it may be necessary to ask manufacturers to lessen the amount of Freon 11 in spray can mixtures.

The internist said animal experiments

have demonstrated that nothing happens when concentrations of up to 150,000 parts per million—or 15 per cent—of Freon 11 are inhaled. Between 15 per cent and 20 per cent results vary, but when the concentration is above 21 per cent death is inevitable.

On the other hand, concentrations of as much as 95 per cent of Freon 12 are not deadly, he said.

A study in beauty salons showed that the maximum concentration around the head of an operator who is applying hair spray is 250 to 310 ppm. In a closed bathroom, the greatest concentration is 50 ppm.

Dr. Horan noted that the fluorocarbon propellants are similar to halothane.

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INGESTIBLE

BREATHABLE

DROPPABLE

SPREADABLE

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TALKING OVER VALIUM®(diazepam) THERAPY WITH YOUR ANXIOUS PATIENT.



A patient often benefits by a greater understanding of his treatment program. You may find it helpful to make your patient aware that the purpose of therapy with Valium is to help reduce discomforting and disabling symptoms of excessive psychic tension and anxiety. It is beneficial for him to understand that much of his tension and anxiety can be relieved by your reassurance and counseling, and that these measures can do more than anything else to help him cope with his basic problems. The patient is reassured in knowing he can expect his medication to help him avoid feeling overwhelmed by his symptoms. And it's also good for him to realize that he will be taking Valium only as long as he needs it.

Your expressed confidence in the medication prescribed, and the positive atmosphere in which therapy is given and accepted, work to the patient's advantage.

Selection of a dosage regimen is an important consideration when Valium (diazepam) is prescribed, and dosage should be individualized to achieve maximum beneficial effect. If the patient understands clearly when and how much to take, and if he knows why it's to his benefit to follow the regimen closely, the chances are better that he will take the medication precisely as directed. That should help avoid missed doses and discourage taking too much or too little medication—all of which can have an undesirable effect on the management of the patient's condition.

*"I'll see you again the week
after next and we'll see
how you're making out."*

Your patient is often likely to feel reassured when you talk about seeing him again to check his progress. A planned visit evidences your continued interest and affords the patient an opportunity to report improvement he has made and to relate whatever continuing or additional difficulties he may be experiencing. It's also a chance for him to describe his response to therapy with Valium.

During follow-up visits, as your patient talks about his medication and about its effects on his symptoms, he will provide the kind of information that will be of great help in evaluating total therapy, adjusting the dosage of Valium, or discontinuing the medication entirely if that seems indicated.

Valium®(diazepam)
2-mg, 5-mg, 10-mg scored tablets
for individualized treatment of psychic tension



Please see the following page for a summary of product information.



Valium® (diazepam)

2-mg, 5-mg, 10-mg scored tablets

Prompt, effective action. Valium (diazepam) works rapidly to relieve pronounced psychic tension in patients overreacting to stress and in psychoneurotic patients.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients.

Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other anti-

depressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10.



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Clinical Trials



MEDICAL TRIBUNE FOR REPORTERS

Female Lag in Performance 'Not Due to Inherent Ability'

Medical Tribune Report

SAN FRANCISCO—The performance and physiological differences noted between male and female athletes may be socially and culturally induced and have little to do with physical differences, a physician-coach said here at a sports-medicine seminar.

His studies suggest that the big differences found between untrained men and women are "not due to inherent ability," said Dr. C. Harmon Brown, director of student health services at California State College at Hayward.

For instance, he reported, young girls increased their oxygen uptake by about 25 per cent after six weeks of training—which was "as good as if not better than in boys." The girls showed normal growth and no sign of any changes that might be harmful, he noted.

Comparisons also showed that the maximum oxygen uptake of trained women athletes compared well with that of college distance runners despite the big differences among the untrained, Dr. Brown said.

With regard to excess adipose tissue—about 25 per cent in untrained high-school and college girls, compared with 14 to 15 per cent in untrained men—he found that the female distance runner has about half as much adipose tissue as her sedentary counterpart. During altitude training for the 1968

Olympics, adipose tissue was 8 to 9 per cent of body weight for the women, quite comparable to what is found in male athletes, he said.

Dr. Brown also observed that the trained adult woman, although she perspires less, appears to regulate body temperature as well as a trained adult man, and that women's muscles can show significant gain in strength through weight training without the same muscle hypertrophy found in men.

He cited a strength increase of 45 per cent with an increase in the lean muscle mass of the arms of only 1-2 per cent and of the legs of 4-5 per cent.

This difference between the sexes is probably hormonal, he said.

The seminar was cosponsored by the American Academy of Podiatric Sports Medicine and the California College of Podiatric Medicine.

Artificial Elbow



Four patients suffering severe pain and inability to move their elbows have undergone total elbow replacement at University Hospitals in Cleveland. The artificial elbow is a hinge joint made of Vitallium and bonded to bone by methylmethacrylate. Dr. Kingsbury Heiple and Dr. Victor Goldberg, the surgeons, report functional mobility and absence of pain in all cases.

IMMATERIA MEDICA

Did You Say Work?

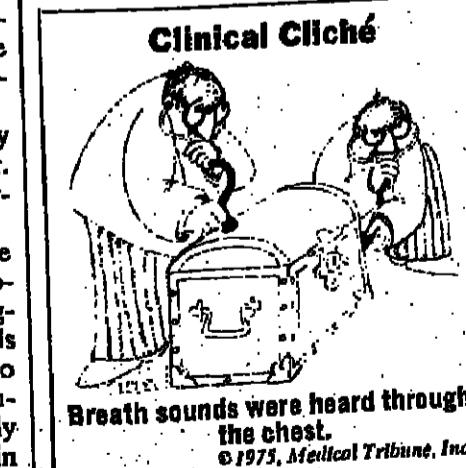
Work Is Dangerous to Your Health is the title of a book that turns out to be a handbook on health hazards of an occupational type—and not one selling laziness. We were so disappointed we looked in the opening pages and learned this title was developed in 1947 by the senior author, Jeanne M. Stellman, Ph.D. Her coauthor is Dr. Susan M. Daum, a physician concerned with occupational health. Looking further, we found an astonishing coverage of such diseases as well as a listing of the hazards of pipefitters, herbicide makers, fishermen, glue makers, rubber vulcanizers,—even physicians, nurses and scientific workers.

Yet not a word about showgirls, musicians, nightclub comics, Presidents, golfers, surfers, sunbathers, Medical School Deans, state hospital superintendents, godfathers, bosses, partners, editors, wives—the people who count.

The Hot Golf Ball

Goodrich Products, Inc., asserting that a hot golf ball will soar 20 per cent farther than a cold one, has marketed a compact portable heater which fires up three balls at once. What's more, Goodrich claims that once heated, the balls retain their soar power throughout the game. The heat reportedly increases its compressibility and resiliency so that it spins faster, increasing its projection.

We always thought our trouble was our swing. What a relief to know it's just those half-baked balls.



Breath sounds were heard through the chest.

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Some Families Found Prone To Several Types of Cancer

Medical Tribune Report

DENVER—Recent evidence suggests that some families are susceptible to groups of apparently unrelated cancers. Dr. Joseph R. Fraumeni, associate director of the Epidemiology Branch of the National Cancer Institute, said here.

Healthy members of such families may deserve increased medical surveillance if they present with subclinical abnormalities, he told the National Conference on Advances in Cancer Management here, sponsored by N.C.I. and the American Cancer Society.

Over the past three years, Dr. Fraumeni said, studies carried out at N.C.I., Creighton University, and M. D. Anderson Cancer Center, Houston, have turned up about 75 families with genetic defects that appear to transmit a disposition to more than one form of cancer. For example, some families seem to be prone to both leukemia and breast cancer, others to cancer of the brain and the adrenals, and others to cancer of the colon and the endometrium.

"Supporting this possibility," he said, "is the observation that the neoplasm that occurs either in familial aggregation or in genetic syndromes tends to develop at an earlier age than do nonfamilial occurrences of the same tumor and tends to arise multicentrically in the same organ or bilaterally in paired organs."

Other recent epidemiologic surveys